Current COBRA Participant

(COBRA Participant same as COBRA Beneficiary)

Instructions: This form requires completion for those who are enrolled into COBRA at the time the group becomes effective with ASI and should be sent to our office. Please see our contact information below.
Important: If the event date was between 9-1-08 and 5-31-10, please specify whether the event was voluntary or involuntary in the appropriate box below

Employer Name: _____

Name of Primary Beneficiary: _____ **Beneficiary's Social Security #:** _____

First Date of Coverage: _____ **Beneficiary's S Mailing Address:** _____

_____

Qualifying Event Information:

Primary Beneficiary's Qualifying Event: ☐ Termination ☐ Resignation/Retirement ☐ Reduction of hours

☐ Voluntary ☐ Involuntary

Dependent Qualifying Event: ☐ Divorce or legal separation ☐ Child no longer eligible ☐ Death of covered employee

Paid Through Date: _____
Date the beneficiary's COBRA premium was paid through prior to the group's effective date with ASI.

Date of the Qualifying Event: _____
Date Loss of coverage began or date of termination.

Qualified Beneficiaries:

☐ Employee Name: _____ Date of Birth: _____

☐ Spouse Name: _____ Date of Birth: _____

☐ Dep Child Name: _____ Date of Birth: _____

☐ Dep Child Name: _____ Date of Birth: _____

☐ Dep Child Name: _____ Date of Birth: _____

☐ Dep Child Name: _____ Date of Birth: _____

Spouse or Dependent Address:
Complete if address is different than the primary beneficiary's address above.

_____

_____

Health Plans:

☐ Medical Carrier: _____ Rate Area: _____

☐ Dental Carrier: _____ Rate Area: _____

☐ Vision Carrier: _____ Rate Area: _____

☐ Other Plan/Carrier: _____ Rate Area: _____

☐ Section 125 Plan: _____ Election Amount and Balance: _____ (Amount / Balance)

_____ _____
Signature of Employer or Employer Representative Date

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